

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010987
STATE FILE NUMBER
2-1873

MAR 18 1959		Registration District No. _____		Primary Registration District No. _____		Registration No. 1873	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST. LOUIS</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>				c. CITY OR TOWN <u>Clayton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hosp</u>				Length of stay in lb _____		d. STREET ADDRESS (If outside, give location) <u>#1 Southmoor</u>	
3. NAME OF DECEASED (Type or print) First <u>ERWIN</u> Middle <u>CARL</u> Last <u>HARMS</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 5, 1896</u>	
9. AGE (In years) <u>63</u> (birthday)		10. FUNDER 1 YEAR Months _____ Days _____		11. IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>president</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco Co.</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13a. FATHER'S NAME <u>Henry Harms</u>				13b. MOTHER'S MAIDEN NAME <u>Unknown Gross</u>		14. NAME OF HUSBAND OR WIFE <u>Gayle Anderson Harms</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u> <u>W.W.I</u>				16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Gayle Harms, #1 Southmoor Clayton 5, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured abdominal aneurism</u> <u>arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>451x</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>451x</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>451x</u>			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>451x</u>		20f. CITY, TOWN, OR LOCATION <u>451x</u>		COUNTY _____ STATE _____	
21. I attended the deceased from <u>1947</u> to <u>May 1959</u> and last saw her alive on <u>2/22/59</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>O.P.J. Falk</u>		(Degree or title) <u>M.D.</u>		22b. ADDRESS <u>18 So. Kingshighway</u>		22c. DATE SIGNED <u>1/23/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>2/24/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis</u> <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>C.R. Lupton and sons 7233 Delmar Blvd</u>				25. DATE RECD. BY LOCAL REG. <u>FEB 24 '59</u>		26. REGISTRAR'S SIGNATURE <u>Harold Smith M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

(Haines)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Arnold W. Schoene*

Licensed Embalmer No. *3864*

P. O. Address *St. Louis, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.